Understanding Inequalities in Access to Health Care Services for Aboriginal People
A Call for Nursing Action

Brenda L. Cameron, PhD, RN;
Maria del Pilar Carmargo Plazas, PhD, RN;
Anna Santos Salas, PhD, RN; R. Lisa Bourque Bearskin, MN, RN;
Krista Hungler, MSc

We present findings from an Access Research Initiative to reduce health disparities and promote equitable access with Aboriginal peoples in Canada. We employed Indigenous, interpretive, and participatory research methodologies in partnership with Aboriginal people. Participants reported stories of bullying, fear, intimidation, and lack of cultural understanding. This research reveals the urgent need to enhance the delivery of culturally appropriate practices in emergency. As nurses, if we wish to affect equity of access, then attention is required to structural injustices that act as barriers to access such as addressing the stigma, stereotyping, and discrimination experienced by Aboriginal people in this study. **Key words:** *Aboriginal health*, *access to health care*, *health inequalities*, *CBPR*, *Indigenous methodologies*, *hermeneutic phenomenology*, *partnership*, *nursing*, *social justice*

Author Affiliation: *Faculty of Nursing, University of Alberta, Edmonton Clinic Health Academy, Edmonton, Alberta, Canada (Mss Cameron, Salas, Bearskinand and Hungler and Dr Plazas).*

Correspondence: *Brenda L. Cameron, PhD, RN, Faculty of Nursing, University of Alberta, 3rd Floor Edmonton Clinic Health Academy, University of Alberta, 11405 87 Ave, Edmonton Alberta, T6G 1C9, Canada (brenda.cameron@ualberta.ca).*

We're all equal people; we have two arms, two eyes, a nose, a mouth, we can talk and walk— you know, we shouldn't be treated differently. That's how I felt like I was being treated: like I was just a different colour. It took a while for me to get a room.

Research participant in ED

GLOBALLY, INEQUALITIES in health and lack of optimum care and treatment of vulnerable groups continue to be a point of debate for nursing organizations, health care providers, and researchers alike.[1] In this article, vulnerable populations refer to those individuals who experience a heavier burden of disease and suffering than other population groups.[2] In Canada, Aboriginal people are a vulnerable population given that they bear a higher number of inequalities than

their non-Aboriginal counterparts.[2] While inequalities in health and social well-being for vulnerable groups persist, the current debate is about what we, as nurses, can do about them.[3] Health inequalities are closely linked to social determinants of health such as socioeconomic status, lifestyle, geographical location, age, gender, and community background.[4] The health of the vulnerable, together with the social gradient in health within countries and the marked health inequalities between countries, has led to unequal distribution of power, goods, income, and services, locally, nationally, and globally. Research evidence has shown that people from vulnerable groups suffer more illness and die younger[5] and are less likely to receive or benefit from optimum access to health care services.[6]

The Indigenous people of Canada are referred to as Aboriginal peoples who, under the Canadian Constitution Act (1982), include 3 distinct groups: First Nations, Inuit, and Métis peoples of Canada.[7] Each one of these distinctive groups has unique histories, heritages, cultural practices, spiritual beliefs, and languages.[8] In Canada, many programs and services have been organized to reduce social and health inequities, yet certain trends for vulnerable communities continue to raise concerns.[4] Aboriginal individuals have higher mortality and morbidity rates and a lower life expectancy than their non-Aboriginal counterparts.[9] Canada ranks fourth on the Human Development Index. Yet, rural Aboriginal communities and Aboriginals residing elsewhere in Canada rank 68th and 36th, respectively.[10] Research has shown that the health of Aboriginal people is less favorable than the health of the non-Aboriginal population.[9] In fact, Aboriginal people face more challenges than the general population in maintaining an acceptable level of health and more of their health care needs remain unmet. Equal access to health care services is important for reducing social inequalities in health. However, Aboriginal individuals perceive access to health services as very difficult and limited. Access remains inadequate

because the link between the local control of health services and practices is not given proper consideration. As well, the cultural meanings of health are not given sufficient weight, and health disparities are not adequately addressed.[11] Research has been designed to document rather than change these trends. Nurses are called on to reinvest in a social justice agenda to decrease health inequalities for vulnerable groups.[3,4] To restructure social relationships to promote equality, nurses need first to be educated on how unequal relationships are created and sustained in society.

In this article, we report findings about the experiences of access to health care for Aboriginal people seeking emergency care in a large Western Canadian city. These findings are from an access research initiative with Aboriginal peoples and inner city residents in a Canadian province aimed at reducing health disparities and promoting equitable access to health care. Following the guidance of Aboriginal partners, we designed an Aboriginal-based intervention to facilitate the access experience of Aboriginal people in emergency departments (EDs). This intervention consisted of the placement of 2 community health representatives (CHRs) in the EDs of 1 large urban hospital and 1 rural hospital that served Aboriginal communities. Community health representatives are Aboriginal health care workers viewed as community health agents in their local communities. Through participatory qualitative methods, we sought to explore the feasibility of implementing in a clinical setting a successful practice intervention in Aboriginal communities in Canada where CHRs have played a key health promotion and liaison role for decades. The relevance of qualitative inquiry to investigate the feasibility and acceptability of practice-based interventions has been stated.[12] Because of space limitations, we focus on 2 major access-related themes of participants' experiences that evoke critical issues of access for this population. This article provides a contribution to broadening nursing action to encompass the social, political, historical, and

economic factors that shape access to health care services for vulnerable populations. In this study, EDs are places that pose access challenges for research participants to secure safe comprehensive care. It is where they consistently experience access situations that engender and perpetuate health inequities for them. Therefore, for the purposes of this research, access to health care in the ED setting is more than accessing emergency care. Rather, it represents a broader view of access for Aboriginal populations. The aim of this article was to reflect on the need to both (1) further broaden the scope of nursing action to explicitly include the conditions that shape access to health care services and (2) examine the structural conditions that influence health and produce health inequalities for vulnerable groups. In the following text, we present health inequalities for Aboriginal peoples in Canada, followed by access to health care services, research approach, and theoretical perspectives informing the study. The research approach of the study is then described, followed by research findings, discussion, nursing mandate to promote social justice for Aboriginal peoples, and future implications.

HEALTH INEQUALITIES FOR ABORIGINAL PEOPLES IN CANADA

In 2011, in the National Household Survey 1 400 685 people identified themselves as an Aboriginal person, representing 4.3% of the total Canadian population. In general, the Aboriginal population is much younger than the non-Aboriginal Canadian population. The median age of the Aboriginal population is just 27 years while it is almost 40 years in the non-Aboriginal group. In contrast, 13% of non-Aboriginal Canadians are 65 years of age and older whereas only 5% of the Aboriginal population is in this age cohort. Data from 2006 census revealed a trend toward aging within the Aboriginal population. The number of Aboriginal peoples aged 65 years and older increased by 43% that year.[8]

Although certain aspects of the well-being of Aboriginal populations have improved, there have been other indications that differences between Aboriginal populations and other Canadians may have been growing in recent years. Cooke and McWhirter[7] examined the average individual income for Status First Nations, finding that between 1981 and 1996, it increased. But during the last decade, the income for First Nations remained nearly constant, while the average income for other Canadians has increased through time. In the same way, Clement[13] explored the university attainment of successive cohorts of Status First Nations, finding that there has been little increase in the proportion with university degrees, resulting in a widening gap with other Canadians. Overall, Aboriginal people's health in Canada continues to lag behind that of other Canadians, which leads to perpetuating inequalities for this group.[7]

In terms of health, in spite of some recent improvements in health indicators; it is widely recognized that there are major inequalities in health between Aboriginal peoples and non-Aboriginal Canadians.[4] Aboriginal peoples continue to suffer a heavier burden of illness, as well as the onset of chronic illness and disability at younger ages than their non-Aboriginals counterparts.[14] In large part, this disparity can be attributed to the social, political, and colonial history that Aboriginal people have experienced,[15,16] the dominance of biomedical perspectives in the health care system,[15] the power imbalances within health care services,[9] and the limited access to health care services.[10] Therefore, the development of initiatives that examine how these conditions interact, bring about, and perpetuate inequities in these populations as well as how to take research to action to address present health gaps is urgent.

ACCESS TO HEALTH CARE SERVICES

Access to health care services entails not only the ability of individuals or groups to obtain required services but also how the services are delivered at point of care. Access is widely regarded as an important social determinant of health.[14,17] In Canada, access to

health care services is universal to all its citizens under the Healthcare Act, and the system is well known in the world as one of the best. Under the Healthcare Act, access is defined as the equitable distribution of services to those in need for the common good and health for all residents. However, equitable access does not imply that everyone receives the same number of services but rather the fair and just distribution of resources, where the service provided is based on need.[17] Yet, not all Canadians have equal access to health care services. Persistent inequalities in health status and access to health care services for Aboriginal people represent serious concerns as they also face barriers to achieve equitable access.[15,17,18]

Aboriginal peoples also tend to experience access to health care services as more problematic than their non-Aboriginal counterparts.[19] In the 2002–2003 First Nations Regional Longitudinal Health Survey, 35% of respondents felt that their access to health care services was less than Canadians in general. A study reporting health services use by First Nations in Manitoba found that while the health status of First Nations people is poorer than Manitobans in general, their access to specialists was overall significantly lower than that of their non-Aboriginal counterparts.[20] According to the 2003 National Aboriginal Health Organization poll,[21] 18% of First Nations respondents indicated that they had not received needed health care in the past year compared with 12% in the Canadian population. Long waiting times was the primary reason not to access needed care. As well, while 67% rated positively the quality of health care received, 24% rated their care as worse than that of Canadians. Lack of quality care and inaccessibility were among the main reasons related to participants' ratings of the care received. Fifteen percent of respondents in the National Aboriginal Health Organization poll reported unfair or inappropriate treatment from a health care provider in the past year, the majority of these being in off-reserve settings.[21] Most indicated their aboriginality as the main reason for inappropriate treatment. There have been many approaches and efforts to understand inequalities in access to health care services and outcomes for Aboriginal people at a population health level.[18] Yet, there remains a gap of knowledge concerning the social and contextual factors influencing access, particularly from the perspective of Aboriginal people. These subjective data are absent, poorly represented, and undervalued in the scientific literature.[15] We address this gap of knowledge by exploring the perspectives of Aboriginal people seeking access to health care services in an urban ED. The need for this specialized knowledge of subjective data is significant, as it will assist us to improve our understanding and develop stronger culturally appropriate nursing practices for Aboriginal people in EDs.

RESEARCH APPROACH

This study builds upon a community request issued in 2002 by Aboriginal community members where access to health care services was identified as a priority issue.[9] Following this request, we undertook 3 qualitative exploratory research projects to investigate Aboriginal peoples' experiences of access to health care services in the urban, rural, and inner city settings. Our approach for these projects was foremost a conversational and relational one, as we engaged in a dialogue with Aboriginal people, health care professionals, and university researchers to create a venue for all voices and concerns to be heard. Research findings revealed the urgent need to develop strategies to promote culturally comprehensive care in acute care settings. In addition, the honesty and forthrightness that was achieved in these circles of conversation as we came to know each other, laid the groundwork for the development of a safe community-based research approach to investigate their concerns of access. Therefore, building on the aforementioned findings along with the research approach, we undertook our reducing health disparities research study. The overall research goal of this study was to investigate and address inequities in access to health care services for Aboriginal peoples and inner city residents

in partnership with Aboriginal people, health care professionals, and university researchers. A related aim was to build a space for knowledge exchange among these partners while delineating elements of respect and reciprocity.

This study followed a combination of Indigenous,[22] participatory,[23] and interpretive[24] research methodologies. An Indigenous methodology is a research approach by and for Indigenous peoples, using techniques and methods drawn from their millenarian cultures and traditions.[25] In Indigenous methodology, the process of research is more than the production of new knowledge. It entails pedagogical, political, moral, and ethical principles that resist oppression and reflect the unique knowledge, beliefs, and values of Indigenous communities.[26] This methodology allows Indigenous people to make their own decisions about research question/topic and research processes without any outside interference. It gives to Indigenous communities control over their ways of knowing and the development of Indigenous knowledge.[25] For non-Indigenous researchers, an Indigenous methodology allows the researcher to enter into the world alongside Indigenous experience rather than framing the Indigenous world-view from a distance.[26]

Community-based participatory research employs frameworks that have potential to complement Indigenous methodologies.[25] Community-based participatory research addresses how the research should be conducted, rather than which techniques should be used in gathering the data. Community-based participatory research integrates scientific research with education and political action. Community-based participatory research encourages participation by the people being studied in all phases of the research process, including design, data collection and analysis, and dissemination of research findings. Community-based participatory research challenges traditional power hierarchies and imbalances and is intended to contribute to a process of shifting power. It provides participants with an opportu-

nity to challenge existing structures and processes.[26]

In this study, the interpretive approach was enacted through a hermeneutic phenomenological methodology as outlined in the human sciences philosophical tradition.[24] In hermeneutic phenomenology, context and experience are crucial to knowing, and the knower is a large part of what is known.[27] Hermeneutic phenomenology is compatible with Indigenous methodologies, because it captures oral history in a holistic and culturally acceptable way.[27] Description and interpretation were the key methodological strategies from hermeneutic phenomenology that we followed.

ABORIGINAL ADVISORY COMMITTEE

An Aboriginal advisory committee led by Dene Elder Rose Martial and comprising Aboriginal community members, stakeholders, health care professionals and researchers was established prior to the study. For this study, members of the Aboriginal advisory community were involved in (1) the design of data collection tools (eg, semistructured questions for interviews); (2) assisted to adapt approaches to increase the cultural sensitivity of study methodologies; (3) provided feedback on the interpretation of results; and (4) assisted with the dissemination of results. Although a collaborative partnership between researchers and Aboriginal community members and stakeholders had been previously established, the specific formation of an Aboriginal advisory committee was essential to this research study. They provided ethical guidance throughout the study. Ethics approval was granted by the University Health Research Ethics Board. Throughout the research, we followed National Aboriginal Health Organization guidelines regarding ownership, control, access, and possession of research data.[28] We also followed the Canadian Institutes of Health Research[29,30] guidelines and Tri-Council Policy Statement[31] for the conduct of research with Aboriginal populations.

THEORETICAL PERSPECTIVES INFORMING THE STUDY

This research initiative is informed by a health equity model developed by Reutter and Kushner[3] to promote health equity with vulnerable populations. Reutter and Kushner outline a nursing mandate to promote health equity that begins with acquiring an understanding of the context of inequities. Once this context is understood, the provision of sensitive, empowering care can follow. Tackling inequities means examining current government ideologies that shape the quality of social determinants of health surrounding individuals and communities. The integration of these 3 components is a crucial axis in the development of research to address inequities with populations who embody them.

The second theoretical model that guided us in the engagement process with Aboriginal communities and partners was the Cultural Safety Framework. It assisted us in the design of the CHR intervention. During the last decade, a Maori researcher identified cultural safety, a relatively new concept, as an outcome of cultural competence.[32] Ramsden[32] asserted that cultural safety extends the current definitions of culture competence beyond personal characteristics, and that health care professionals need to understand self and their own culture and theory of power relations. The author defined cultural safety as an outcome of care that enables those who receive services to define safe care. Cultural safety encourages the health care practitioner to address the historical and political issues surrounding the delivery of health care services in the Aboriginal population. Ramsden[32] described it as a critical appraisal and analysis of the political movements of self-determination, decolonization, institutional discrimination, and power imbalances in the health care system.

Cultural safety is based on critical social theory; it is the outcome of learning to work with Indigenous people and is defined by those who receive it. Cultural safety is built on the principle of biculturalism. Cultural safety is not about cultural practices; rather, it involves the recognition of the social, economic, and political position of certain groups within society, such as the Aboriginal people in Canada, and the consequent impact on their health.[33] The current discourse on cultural safety is an attempt to integrate concepts of culture specific to Aboriginal health services into health care practices.[33,34] One of the key principles of cultural safety is protection against individual, structural, and institutional racism. In addressing these challenges in nursing education, 3 national nursing bodies (Aboriginal Nurses Association of Canada, Canadian Nurses Association, and Canadian Association of Schools of Nursing) collaborated on a project to articulate a cultural safety framework that would identify best practices in relation to First Nations, Métis, and Inuit students. The framework lists core competencies considered important to creating a culturally safe environment. The competencies—postcolonial understanding, Indigenous knowledge, respect, communication, inclusivity, mentoring, and support are considered to be important areas for further development.[33]

DATA COLLECTION

Data collection methods included digitally recorded semistructured interviews. Participants were Aboriginal patients and families able to communicate in English or Cree and stable in terms of their illness presentation. The sample consisted of 19 participants, 84% women and 16% men, in the urban study, and 35 participants, 77% women and 23% men, in the rural study. Potential participants received written and verbal information about the study by the triage nurse or a delegate. Participants were accrued through the ED navigator on duty who explained the research study and handed the consent form. An Aboriginal CHR then approached the participant and accompanied him or her in consultation with the registered nurse until the person was discharged. The CHR conducted a short 15- to 30-minute audiotaped interview before discharge or during a follow-up call with the

participant in the home. The interview questions focused on the experience of access to emergency care services, the interaction with health care professionals, the barriers to access health services, and the value of having an Aboriginal health care worker in emergency. Having CHRs conduct the interviews was viewed as a culturally safe research practice given that they had been present throughout part of the emergency episode of research participants. Their common cultural background enabled CHRs to achieve relational engagement with participants, and although this may be a study limitation, it was crucial to conduct conversations around sensitive issues of access and the experience of having a CHR. While participants may have been hesitant to express negative views in relation to CHRs, the participatory and relational nature of the study approach did not conflict with this decision. In our view, this provided an opportunity to gain a close understanding of participants' experiences.

The CHR also recorded field notes of the emergency episodes related to each participant (43 in total). These contained contextual information of the ED environment, interactions, and participants' specific situations. Both interviews and field notes were transcribed verbatim and used in the data analysis. The data set was cleaned and organized by an Aboriginal research assistant (R.A.) with health care background and previous research experience. The R.A. was trained by the researchers and the study coordinator in areas related to the study including research methodology, data management, and data analysis. One of the study investigators together with the R.A. verified the accuracy of data by listening to the audio recordings of the interviews. The R.A. actively participated in data analysis, although this process was done together with researchers and other team members as described later.

DATA ANALYSIS

Data analysis was a team process involving Aboriginal and non-Aboriginal team members. Team members included Elder Rose Martial, coinvestigators, the research coordinator, and research trainees (postdoctoral fellows, graduate, and undergraduate students). The analysis process entailed reading the transcript and the field notes together while listening to the digital recording of both. We also asked questions to the CHR for missing data or clarification questions. The analysis of textual data followed a thematic analysis according to van Manen.[24] The overall approach encompassed 3 steps: first transcripts were read as a whole to understand the elements present in the text; second, transcripts were read to search for phrases that seem to be particularly revealing about the experience; and third, a detailed sentence-by-sentence reading of the text was undertaken to highlight statements that were essential to the experience being described. As we started to see commonalities in the data across the transcripts, we named the theme with words directly used in the transcript. Several themes were generated, refined, and documented in tables, with excerpts from interviews and field notes and comments by the research team. A track sheet was also developed to record progress. These themes are very clearly grouped together with no intent of raising them to a further conceptual level but staying with the phenomenological analysis of experience. While this seems ordinarily like rigor in the research process, we were more concerned about interpreting the data from the western world-view. Poignantly during the group data analysis process, there were always some Aboriginal understandings and traditions that the western trained researchers did not know and, therefore, required clarification from the Aboriginal members of the analysis team. Therefore, constant dialogue ensued with a coming to understanding before the data were classified in a common theme. This took much time that is not consistent with the national funding bodies. Yet, it was necessary to honor the Aboriginal request for this intervention to ensure as much as possible that we did not skew the findings. The blending of worldviews required time and patience on the part

of all members of the team. Involvement of Aboriginal individuals was crucial to ensure the rigor of the analysis as they contributed a contextual and cultural understanding to emerging interpretations. The CHRs also took part in data analysis sessions to further situate the analysis in the participants' own experiences in emergency. Elder Rose Martial actively engaged in data analysis, providing her comments in writing and during data analysis meetings. Triangulation of data sources (patients, CHRs, and family members) and methods (interviews, field notes) also enhanced analysis and interpretation. Community health representatives' field notes enhanced reflexivity as they further reflected upon participants' experiences and their own at the end of their shifts. Finally, the story format to present findings was a way to portray an in-depth understanding of emerging themes that also aligned well with the Aboriginal world-view.

To ensure the overall methodological rigor of this study, Lincoln and Guba's (as cited in reference Creswell[35]) criteria were followed as outlined in the Table. We also adhered to the principles of Indigenous Research Methodologies[36] to enhance the Indigenous rigor of this study including respect, responsibility, relevance, and reciprocity.[37]

MAJOR RESEARCH FINDINGS RELATED TO THE EXPERIENCE OF ACCESS TO HEALTH CARE

In line with the guidelines of Indigenous research methodologies and the hermeneutic phenomenological tradition, we present 2 compelling stories that evoke major access themes of participants' experiences. The stories are based on transcript data from interviews with participants. Information from field notes was incorporated when necessary. The stories are true descriptions of the participant's own account and only minor editorial changes were made. Each story is followed by a hermeneutic phenomenological interpretation that highlights key themes that emerged in the data analysis process. Consistent with interpretive inquiry,

Table. Qualitative Rigor Criteria and Activities

Credibility
Guidance from an Aboriginal Elder Rose Martial throughout the research process
CHRs were both First Nations people. Involvement of Aboriginal research assistants
Shifts organized around peak consultation hours for Aboriginal people (eg, evenings and weekends)
Involvement of Aboriginal partners in the research and decision-making processes
Thorough documentation of research process by research study coordinator
Transferability
Rich descriptions of themes through participants' stories
Involvement of Aboriginal participants who were from urban, rural, and remote settings. Diverse sample in the urban setting as participants came from various communities and places
Confirmability
Dissemination to Aboriginal communities through popular theater methodology involving Aboriginal youth to promote their engagement in discussion of findings
Findings shared with Aboriginal stakeholders
Dependability
CHRs shared the Aboriginal world-view with research participants
Extensive on-site engagement
Findings shared with emergency department managers and Aboriginal stakeholders
Process of situating the findings in context ongoing

Abbreviation: CHRs, community health representatives.

literature is intertwined in the discussion of findings as a way to develop linkages between participants' experiences of access, related literature, and relevant theoretical perspectives. In the first story, an Aboriginal woman from a remote community in Canada describes her own experience in urban acute settings. In the second story, a participant from the inner city area describes his own struggles to access care as an Aboriginal man and how the presence of an Aboriginal CHR reaffirms his sense of humanness.

Story 1: When you are lonely you can delay your recovery

What I want is someone to be there as a translator because sometimes we don't understand especially high words in English when we are questioned by the staff. When we are scared or fearful we cannot just ask anyone for help because we don't know anyone here. It would be helpful to have someone in the hospital who speaks Cree. Last October, when I was brought in here I was scared a lot as I didn't know what was going to happen to me or how my illness was going to be. I was so sick. I couldn't walk. My escort just left me there. I was alone and so worried. I had no one to help me or even to translate for me, no one to support me when I am worried and confused. This time it was not as bad because my daughter came with me as an escort. I felt I was treated alright. She stayed with me till I was moved to the unit. I felt this time around the staff treated me good. Last time when I was here I couldn't understand what the staff was saying to me because I was so sick. No one was there to translate for me if I wanted painkillers or even to phone my family for me. I was in need of help. This time I understand as the doctor talked slow to me and when I don't understand the question I asked him to explain to me better. I feel more comfortable now. I feel a little ease this time.

A lot of the people from my community have experienced the same problem here. More likely the young people, when they come in as escorts they are scared. Some will just sleep on the floor beside the patient just because they are scared to ask questions to the staff. Just like this one escort recently, she ended up sleeping on the floor with just a white sheet as she was exhausted and hungry just because she was afraid to ask for help. So she just slept there on the floor beside the patient. That's why I say people are in need of help. Even these young people that talk a little English they are not great escorts as they are also very shy because we come from isolated area that is why they are shy. Some are shy or scared to say something wrong and be laughed at. So I think a CHR would be an asset to have at the hospital. When a person is here alone they need a lot of support. Also when you are lonely you can delay your recovery. I want to see a CHR here always to work here. I am so happy that you [CHR] worked with me. You come visit me and you gave support in many ways. I want a CHR here, someone who talks Cree and is friendly and helpful. It is so important to have someone who is not hard on people. You are friendly and not reluctant to talk to people.*

In this story, an Aboriginal woman recalls how Aboriginal people experience access to emergency services in the city when they come from a remote area in Canada. Being away from home was a scary experience that placed emotional hardship on her life. She felt alone and missed her family and community. Her escort left her alone in the hospital, and without fluency in English, she struggled to communicate her immediate needs to the health care professionals. Yet, her story is not unique. Other members of her community have faced the same situation. According to Health Canada,[38] despite access to adequate health care is a right of every Canadian as guaranteed by the Canada Health Act of 1982, people who do not speak English or French languages become part of those who do not receive appropriate health care services in Canada. Without effective communication, her needs and characteristics of the person were not assessed by health care providers. She was a mere spectator of their actions. This could impact her health and sense of worth and could result in feelings of despair and hopelessness. Safe access to

---

*Escorts are Aboriginal individuals from the same community who accompany Aboriginal individuals when traveling from rural or remote to urban hospitals for health care in Canada.

health care continues to be a critical need for most Aboriginal communities.[39]

The Western understanding of health is individualistic. Aboriginal culture approaches health in a holistic way as reflected in the Health Council of Canada report on "*Understanding and Improving Aboriginal Maternal and Child Health in Canada*."[40] Aboriginal people believe that wellness is achieved through a balance of the body, mind, emotion, and spirit, and holistic health requires the family and community to work together; in other words, "it takes a healthy village to raise a healthy child."[40(p5)] Each part enhances, supports, and affects the other. Individual wellness is the result of how each of these factors is addressed. Although each Indigenous group across the world has its own distinct culture, language, history, and unique way of life, Indigenous people share common values derived from an understanding that their lives are part of and inseparable from the natural world. Balance, health, and healing require that an individual live in harmony with others, their community, and the spirit worlds.[41] The notion of "life is health is life" was at the root of Aboriginal women's view of health in a study conducted in Australia.[42] Women in this study highlighted the intimate relation between their own health and the health of the community. To experience health, Aboriginal people require a sense of community and a sense of personal identity and the practice of cultural/spiritual traditions.[43] Aboriginal cultures are family-based cultures operating within an extended family system.[39] For Aboriginal people, each member of the community is the concern of the entire community. This participant needed to feel supported by family and health care providers. In the moment of illness, knowing someone is with us can significantly influence the comfort we experience.[6] Her daughter and CHR provided support and comfort to ease her experience of illness. For this participant, the CHR was a supportive Aboriginal worker who brought knowledge, comfort, and company in the foreign environment of emergency. Community health representatives play a key role in building partnerships and trusting relationships with patients and their families to support and encourage access to health care services.[44] Through this study, the CHR shared her experience, knowledge, and wisdom to create understanding, bridge cultural differences, and to influence individuals and systems supportive services for Aboriginal participants. Community health representatives had an ability to instantly connect with Aboriginal people from any community in Alberta as well as inner city residents, make the people feel safe, interpret health and care concerns to the appropriate health care professional, garner a more comprehensive history, and assist in the participant's comfort, and their very presence anecdotally cut down on some discriminatory practices whether intentional or not.

There are many things that health care providers can do to foster a sense of belonging for Aboriginal people in health care settings, connecting them to the information and supports that they need in a respectful and caring manner and acknowledging their strengths. There is a sense of solidarity and community in Aboriginal peoples that we need to understand and never forget. To respect someone is to recognize the other's place in the world. The recognition of the other implies that we are part of the other, share in the other's world, with the possibility to know more about the universe of the other, and in that way, start a relationship of mutual interchange of experiences and interact in specific situations. Interaction implies being part of the other's world, and the interchange of experience is always under parameters of mutual respect and recognition. It is through this recognition and interaction that we perceive the other in a vocative way.[45] Respect is the show of consideration for Aboriginal peoples, their families, and communities for whom they are their uniqueness and diversity.[39]

Story 2: Being treated like a person

At this hospital, one of the things I liked is I wasn't treated differently; like, it's hard to

explain unless you're native. Like, unless your Aboriginal, it's really hard to explain. Like, when you walk in some place, you're automatically treated—most places, you're automatically treated lesser than or less than, or your problems or your drinking; there always seems to be a negative look at native people when you come into places. The one thing I liked about this hospital was you [CHR]; you were there, and that was very helpful, and the fact that I wasn't looked down—like, "Uh-huh, there's another native person with another problem," and stuff.

Right from the start, I don't know; I was telling you about that when I was in this other hospital, the difference on the way we're treated. Like, when I was in—this is an awful story—the last time I was there was a week ago, and there was a native guy, and he's in there all the time. They literally—the two security guards—he didn't want to leave 'cause he had nowhere to go, he wanted a blanket—they picked him up out of the chair and this great big—I hate to say it—big, overweight security guard kneed him in his little skinny leg. And all he wanted was help; that's all he wanted was help. And I sat there and I watched this, and I'm thinking, "My God." And then they wonder why Aboriginal people get so in your face and so defensive all the time—'cause you get treated like that. But this hospital was better. I just wish it wasn't so far away from down here. It's just hard to get to for people like me that are low-income. 'Cause I can't afford to take the cab.

[It helps] being treated like everybody else. [laughs]. Like, people don't want to say, but Aboriginal people are still treated in a different way, and people don't think that they do, but we are very much treated differently than the rest of society, and it does show and we do feel it. One of the things I don't like—one of the reasons I don't go to Emergency is because of the experiences I've had at this other hospital and at other places, you know, being Aboriginal and kind of being treated like I don't count. So that's one of the reasons why, and then I don't go. I go when I absolutely have to. [laughs]. I like going to [Inner city agency], because the people that work there are trained to deal with—like, we're not treated like there's something wrong with us, basically. You know, even though it is inner city, but we're still treated like human beings.

When you [CHR] came over, it made me—I was much more relaxed; I felt like—you know, I didn't feel like I was going to get picked on or anything; like, I felt like I was going to be okay there. "Yeah [CHR says], I felt that, too, when I came to see you." Yeah [participant says], "There's a person!" [both laugh]. And we need more of that. I didn't feel like, okay—you know, I was treated like a human being, and it was awesome.

Through his story, this participant points to a number of key areas that affect not only his experience in emergency but also his overall health and well-being as lived within the Aboriginal world-view. The story of the fellow man he witnessed is appalling. He presents us with evidence to sustain his claims regarding the experience of discrimination that Aboriginal people go through. He appeals to our ethical conscience and states the urgent need to be treated "like everybody else." These harsh experiences of discrimination—where his personhood is annihilated--affect his access to emergency care as he points out. He contrasts care in an ED with the care he receives in an inner city agency where services are designed to better serve this population's needs. He highlights the difference when workers are trained to work with people who experience complex health needs and offer an understanding mind. A similar case occurs with the presence of the CHR in emergency. A safe space is created and the person as he describes, feels treated like a person.

In the context of Aboriginal people's health, Bourque Bearskin[46] highlights the need to incorporate a philosophy of respect in the workplace. This entails the need to recognize cultural values, to question common assumptions, to foster a trusting relation and a safe space between nurse and patient, to acknowledge cultural individuality, and to "treat people with dignity and compassion."[46(p557)] The story this gentleman tells denounces a profound lack of respect in the treatment of others and the absence of a primordial value, that of recognizing our humanness in each of us.

The aforementioned story also shows how the broader social determinants of health can affect Aboriginal peoples' access to health

care. This patient reports financial problems that often impede low-income people to afford transportation to access care. Reading and Wien[47] identify several social determinants of health that affect the well-being of Aboriginal peoples. This participant's story and other study participants' accounts reveal many of the determinants these authors identify. They outline 3 interrelated categories including proximal—those determinants that directly affect the health of individuals such as health behaviors, physical environments, employment and income, education, and food insecurity; intermediate—those that underlie the proximal ones such as community infrastructure, health systems, educational systems, environmental stewardship, and cultural continuity; and distal—those that configure both proximal and intermediate such as "colonialism, racism, and social exclusion, as well as repression of self-determination."[47(p20)] This participant's story reveals many problems in these 3 categories. First, there are several proximal determinants affected that contribute to his present health status. His story reflects problems with the health system and infrastructure, with the ability to access care that resonates with his culture and own needs. And finally, he offers a vivid report of how he has been exposed to serious and detrimental experiences of discrimination and social exclusion related to his Aboriginality.

Latin American philosopher Enrique Dussel[48] writes that the majority of humanity experiences oppression and marginalization today. In the context of the Americas, Dussel[48] shows how the history of colonization and political domination has forced Indigenous people into exteriority, a place outside the prevailing political, economic, cultural, and social schemes. This participant evokes this state of exteriority when he declares that Aboriginal people "*are very much treated differently than the rest of society . . . .*" He poses the ethical claim upon us to be treated like a human being, or in his own words, the ethical recognition that "*there's a person!*"

DISCUSSION OF FINDINGS

Stories presented in this article highlight elements of the experience of Aboriginal peoples that affect access to health care services. Throughout the study like in these stories, individual interviews and field notes contained many examples of areas that increase vulnerability and disparities for research participants. Participants reported stories of racism, stigmatization, language difficulties, intimidation, harassment, and deep fear. They described coming to ED to have a variety of needs met such as the need for medical attention, access to specialist, laboratory tests, and immediate treatment. However, in their search, as in the stories described previously, they found barriers such as limited access to comprehensive and specialized care, long waiting times, barriers in the communication and understanding of medical jargon, and barriers in the interaction with health care professionals.

Etymologically, the word "access" comes from *accedere*, with *ac* meaning "to" and *cedere* meaning "to come," "to cede," and "to yield."[49] Research participants' experiences encompassed each of these meanings. Held within this word was the notion of ceding, struggling to accommodate themselves and their needs within a rigid, Western health care structure.

In fact, the fear of judgment by mainstream health care professionals affected the quality of interactions at the individual level between the Aboriginal participant and health care professionals and the participants' decision to seek health care services for their own health needs. This fear of judgment occurs in a context of economic and political disadvantage faced by many Aboriginal people in Canada.[15,16,47] Therefore, access to health care services for Aboriginal people cannot be discussed without taking into account factors that continue to impact Aboriginal people's health and well-being.

One striking aspect of the findings was that some participants described ED health care professionals' judgmental behaviors

toward them. Some participants expressed that emergency staff at times did not take the time to further assess participants' needs and concerns or explain health conditions, test results, or even estimated waiting times. And several felt that their health care needs were not well addressed by health care professionals. Also, participants described how previous negative experiences with health care professionals discouraged them from developing a trustworthy relationship with them. These findings are not unique; one element that affects the health of Aboriginal peoples is the tension and distrust that has historically marked the relationship between Aboriginal people and the health care system.[15,18] This situation has over the years prevented the development of culturally appropriate health care services. Participants of this study often recalled stories of stigmatization and marginalization when talking about their health care experiences. The number of studies exploring Aboriginal people's perspectives about the health care system has grown in the past decade. Common themes about their experience tend to emerge. Although stories of compassion and understanding are present in Aboriginal people's accounts regarding their health care experiences,[50] negative events as in this study seem to predominate. As in our research findings, literature describes the effects of misunderstandings with health care professionals, discrimination, loss of privacy, lack of companionship in the hospitals, lack of access to traditional healing practices, and feelings of being neglected and denigrated as persons permeate Aboriginal peoples' experiences within the health care system.[15,16,50] Communication difficulties and dismissal of traditional knowledge are also commonplace in the relationship between Aboriginal peoples and health care workers.[15]

Participants' accounts revealed how the experience in the hospital depends not only on the disposition of the health care team but also on how quickly they accessed needed care. When there was understanding of what was happening, there was satisfaction and recognition of the good work of health care

professionals. However, when care expectations were not met, participants felt powerless and bewildered. Their trust toward health care professionals and health services diminished rapidly. It was hard when health care professionals did not work with them as active participants of the health team. Once they were relegated to mere spectators, the experience of care became frustrating. Our research findings showed the urgent necessity to educate health care professionals about Aboriginal cultures so that sensitive and safe practices may be developed. The need to work in partnership with Aboriginal communities to foster culturally sensitive and comprehensive practices in the health care system is recognized in the literature.[16,50]

Research to date has shown how access to health services has been identified as essential to improve the health status of Aboriginal populations.[11,16] Findings of this study highlight the significance of personal, social, and prior health care experiences in influencing Aboriginal people's access to emergency services. The participants clearly state that accessing care includes first overcoming inhibitions against seeking care because of accumulated past negative experiences. These contexts and experiences are particularly relevant to understand given the health disparities and inequities in access to health care that many Aboriginal people in Canada experience.

NURSING MANDATE TO PROMOTE SOCIAL JUSTICE FOR ABORIGINAL PEOPLES

There are several nursing implications that originate from this study. First, through stories, nurses and allied health care professionals are able to access and understand the lived experience of Aboriginal people in an emergency setting. The stories provide insights into the struggles and needs of participants. These subjective data contribute to broaden the knowledge and understanding of one person's particular situation. They also

enhance reflective practice as it has the potential to move nurses and allied practitioners into further reflection regarding the effect of both their behaviors and the system itself on others. Registered nurses need to be aware of the reasons Aboriginal people access the ED as identified previously. Health care policies often enforce ED staff to carry out care for what is deemed true emergencies. Rather than following these standard policies, nurses as frontline workers need to apply their knowledge of the social determinants of health to mitigate vulnerable people's experiences of inequities in access to ED. Access to cultural safety workshops for health care professionals would be an important component to facilitate culturally safe environments. In addition, an increase in the number of Aboriginal health care workers in health care settings is urgent to ensure the sustainability of culturally safe environments. Further research into how CHRs could enhance the relationship with the health care team can show their relevance within the health care system and provide solid evidence for policy advocacy and change.

To affect equity, nurses need to cast their gaze toward the conditions that perpetuate inequalities.[3,4] For instance, in this study, participants do not access health care for a variety of complex reasons including concerns about stigma related to being Aboriginal, discourses of blame, poverty, and lack of system capacity. Attention is required to these structural injustices that act as barriers to health care services. Structured inequities perpetuated by stigma and discrimination create poor health outcomes.[14] Inequalities in health for Aboriginal peoples cannot be addressed through merely practicing cultural competence at the individual level. Rather, the conditions that hinder access for these populations need to be addressed first. An educational orientation on social justice is necessary to prepare future nurses to address national, local, and even global concerns such as the health inequalities. Educating nursing students about social justice will enable them to enter the nursing profession to be agents of change and compassionate citizens of the world.[1]

To close at the Conference on "Linking our Knowledge through Diverse Interests" Sponsored by the Aboriginal Nurses Association of Canada (2010), Madeline Dion Stout,[51] said this: "The experiences of mpahi kayas (-deadly past, colonization) have to be shifted to wapatikewsiwin (grass roots evidence) and naskomowina (on-the-ground solutions)." This access research study was formulated as a grassroots initiative to address the urgent and long-standing concerns of Aboriginal peoples, and with our work with Aboriginal leaders, the capacity to build local solutions has created fruitful ideas for change. The pathway has been a long and arduous journey. Yet, the evidence generated bespeaks the relevance of undertaking this work together with many partners to build a more humane and more sensitive health care system. The inequities gap that Aboriginal people bear is an ethical and political appeal to take action to close this gap. It is time.

REFERENCES

1. Boutain DM. Social justice as a framework for professional nursing. *J Nurs Educ.* 2005;44(9):404-408.
2. Beiser M, Stewart M. Reducing health disparities: a priority for Canada. *Can J Public Health.* 2005;96(S2):s4-s5
3. Reutter L, Kushner KE. Health equity through action on the social determinants of health: taking up the challenge in nursing. *Nurs Inquiry.* 2010;17(3):269-280.
4. Raphael D. Poverty, human development, and health in Canada: research, practice, and advo-cacy dilemmas. *Can J Nurs Res.* 2009;41(2):7-18.
5. Commission on the Social Determinants of Health. *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health.* Final Report of the Commission on Social Determinants of Health. Geneva, Switzerland: World Health Organization; 2008.
6. Camargo Plazas MdP, Cameron BL, Smith DG. Neoliberal oriented health care system answer to global competition or a threat to health equality for people

with chronic illness. *Adv Nurs Sci.* 2012;35(2):166-181.

7. Cooke M, McWhirter J. Public policy and aboriginal peoples in Canada: taking a life-course perspective. *Can Public Pol.* 2011;37(suppl):S15-S31.

8. Gionet L, Roshanafshar S. *Select Health Indicators of First Nations People Living Off Reserve, Métis and Inuit*. Health Statistics Division Canada. http://www.statcan.gc.ca/pub/82-624-x/2013001/article/11763-eng.pdf. Published January 2013.

9. King M. Chronic diseases and mortality in Canadian aboriginal peoples: learning from the knowledge. *Chronic Dis Can*. 2010;31(1):2-3.

10. Webster P. Canadian Aboriginal people's health and the Kelowna deal. *Lancet.* 2006;368:275-276.

11. Gao S, Manns B, Culleton B, et al. Access to health care among status aboriginal people with chronic kidney disease. *Can Med Assoc J.* 2008;179(10):1007.

12. Leeman J, Sandelowski M. Practice-based evidence and qualitative inquiry. *J Nurs Scholarship.* 2012;44(2):171-179.

13. Clement J. University attainment of the registered Indian population, 1981–2001: a cohort approach. *Horizons*. 2008;10:34-48.

14. McGibbon E, Etowa J, McPherson C. Health-care access as a social determinant of health. *Can Nurs*. 2008;104(7):23.

15. Browne A, Smye VL, Rodney P, Sannie YT, Mussell B, O'Neil J. Access to primary care from the perspective of aboriginal patients at an urban emergency department. *Qual Health Res.* 2011;21:333-348.

16. Denison J, Varcoe C, Browne A. Aboriginal women's experiences of accessing health care when state apprehension of children is threatened. *J Adv Nurs*. 2014;70:1105-1116.

17. National Collaborating Centre for Aboriginal Health. Access to health services as a social determinant of First Nations, Inuit and Métis Health. www.nccah-ccnsa.ca/Publications/Lists/Publications/Attachments/22/Access%20to%20Health%20Services%20(English).pdf. Published 2011.

18. Peiris D, Brown A, Cass A. Addressing inequities in access to quality health care for indigenous people. *Can Med Assoc J*. 2008;179(10):985.

19. First Nations and Inuit Regional Health Survey: National Report 1999. St. Regis, Quebec: First Nations and Inuit Regional Health Survey National Steering Committee, 1999. Print.

20. Martens PJ, Sanderson D, Jebamani L. Health services use of Manitoba First Nations people. *Can J Public Health*. 2005;96(supp 1):s39-s44.

21. First Nations Centre National Aboriginal Health Organization. What First Nations People think about their health and health care: National Aboriginal Health Organization's Public Opinion Poll on Aboriginal Health and Health Care in Canada. http://www.naho.ca/firstnations/english/opinion_poll.php?print=1. Published 2003.

22. Kovach M. *Indigenous Methodologies Characteristics, Conversations, and Context*. Toronto, Ontario, Canada: University of Toronto Press; 2009.

23. Couzos S, Lea T, Murria R, Culbong M. 'We are not just participants—we are in charge': the NACCHO ear trial and the process for Aboriginal community-controlled health research. *Ethn Health*. 2005;10(2):91-111.

24. van Manen M. *Researching Lived Experience. Human Science for an Action Sensitive Pedagogy*. 2nd ed. London, Ontario, Canada: The Althouse Press; 1997.

25. Brown HJ, McPherson G, Peterson R, Newman V, Cranmer B. Our land, our language: connecting dispossession and health equity in an indigenous context. *Can J Nurs Res*. 2012;44(2):44-63.

26. Martin DH. Two-eyed seeing: a framework for understanding indigenous and non-indigenous approaches to indigenous health research. *Can J Nurs Res*. 2012;44(2):20-42.

27. Struthers R, Peden-McAlpine C. Phenomenological research among Canadian and United States indigenous populations: oral tradition and quintessence of time. *Qual Health Res.* 2005;15:1264-1276.

28. Schnark B National Aboriginal Health Organization. Ownership, control, access, and possession (OCAP) or self-determination applied to research: a critical analysis of contemporary First Nations Research and some options for First Nations Communities. *J Aboriginal Health*. 2004;1:80-95.

29. Canadian Institutes of Health Research. Institute of Aboriginal Peoples' Health. CIHR guidelines for health research involving aboriginal people. http://www.cihr-irsc.gc.ca/e/29134.html. Published 2007.

30. Canadian Institutes of Health Research. Research involving the First Nations, Inuit and Métis Peoples of Canada. In Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. Tri-council policy statement: ethical conduct for research involving humans. http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9/. Revision published 2013.

31. Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada. Tri-council policy statement: ethical conduct for research involving humans. www.pre.ethics.gc.ca. Published 2010.

32. Ramsden IM. *Cultural Safety and Nursing Education in Aotearoa and TeWaipounamu*. [doctoral dissertation]. Victoria University of Wellington. Published, 2002.

33. Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing, Canadian Nurses Association. *Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis nursing*. Ottawa, Ontario, Canada: Aboriginal Nurses Association of Canada, Canadian Association of Schools of Nursing, Canadian Nurses Association; 2009.

34. Walker R, Cromarty H, Kelly L, St. Pierre N. Achieving cultural safety in Aboriginal health services: implementing of a cross-cultural safety model in a hospital setting. *Divers Health Care*. 2009;6:11-22.

35. Creswell JW. *Qualitative Inquiry & Research Design*. 2nd ed. Thousand Oaks, CA: SAGE Publications; 2007.

36. Weber-Pillwax C. What is Indigenous research? *Can J Native Educ.* 2001;25(2):166-174.

37. Pidgeon M, Hardy Cox DG. Researching with Aboriginal peoples: Practices and principles. *Can J Native Educ*. 2002;26(2):96-106.

38. Health Canada. *Language Barriers in Access to Health Care*. Ottawa, Ontario, Canada; Health Canada. http://www.hc-sc.gc.ca/hppb/healthcare/equity/index.html. Published 2001.

39. Barlow K, Loppie C, Jackson R, Akan M, Maclean L, Reimer G. Culturally competent service provision issues experienced by Aboriginal people living with HIV/AIDS. *Pimatisiwin*. 2008;6(2):155-180.

40. Health Council of Canada. *Understanding and Improving Aboriginal Maternal and Child Health in Canada Conversations About Promising Practices Across Canada*. Toronto, Ontario, Canada: Health Council of Canada; 2011.

41. King M, Smith A, Gracey M. Indigenous health part 2: the underlying causes of the health gap. *Lancet.* 2009;374:76-85.

42. Kelaher M, Baigrie N, Manderson L, Moore L, Shannon C, Williams G. Community perceptions of health, illness, and care: identifying issues for indigenous communities. *Women Health*. 1998;28(1):41-61.

43. Van Uchelen CP, Davidson SF, Quressette SVA, Brasfield CR, Demerais LH. What makes us strong: urban aboriginal perspectives on wellness and strength. *Can J Commun Ment Health*. 1997;16(2):37-50.

44. Owens L, McKim R, Doering D, Hanrahan A. Evaluation of an inner city public health clinic serving an Aboriginal and non-Aboriginal population. *Pimatisiwin*. 2005;3(2):131-147.

45. Levinas E. The primacy of the other. In: Moran D, Mooney T, eds. *The Phenomenology Reader*. London and New York: Routledge; 2002:509-540.

46. Bourque Bearskin RL. A critical lens on culture in nursing practice. *Nurs Ethics.* 2011;18(4):548-559.

47. Reading CL, Wien F. *Health Inequalities and Social Determinants of Aboriginal Peoples' Health*. Prince George, BC: National Collaborating Centre for Aboriginal Health; 2009.

48. Dussel E. In: Mendieta E, ed. *The Underside of Modernity: Apel, Ricoeur, Taylor, and the Philosophy of Liberation. [Apel, Ricoeur, Rorty y la Filosofia de la Liberacion.] (E. Mendieta Trans.)*. New Jersey: Humanities Press International. Atlantic Highlands, NJ: Humanities Press, 1996.

49. Skeat W. *A Concise Etymological Dictionary of the English Language*. New York, NY, Capricorn Books; 1963.

50. Durey A, Thompson SC, Wood M. Time to bring down the twin towers in poor Aboriginal hospital care: addressing institutional racism and misunderstandings in communication. *Intern Med J.* 2012;42:17-22.

51. Dion Stout M. *Original Instructions for Nursing. Plenary Address at the Philosophy in the Nurse's World Conference "The Politics of Nursing Practice"*. Banff, Alberta, Canada: The Institute for Philosophical Nursing Research; 2010.